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### People and teams matter in organizational change

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## **Abstract**

**Key Words.** Emotions; illness and disease, chronic; relationships, healthcare; health policy/policy analysis.

**Study Objectives.** To explore the experiences of governance and incentives during organisational change for managers and clinical staff.

**Study setting.** Three primary care settings in England in 2006-8.

**Study design.** Data collection involved three group interviews with 32 service users, individual interviews with 32 managers and 56 front-line professionals in three sites. The Realistic Evaluation framework was used in analysis to examine the effects of new policies and their implementation.

**Principal findings.** Integrating new interprofessional teams to work effectively is a slow process especially if structures in place do not acknowledge the painful feelings involved in change and do not support staff during periods of uncertainty.

**Conclusions.** Eliciting multiple perspectives, often dependent on individual occupational positioning, or place in new team configurations, illuminates the need to incorporate the emotional as well as technocratic and system factors when implementing change. Some suggestions are made for facilitating change in health care systems. These are discussed in the context of similar health care reform initiatives in the United States.

## **Introduction**

In this article we discuss findings from a three-centre study in England, which explored the professional experience of evolving organisational and governance structures in primary health and social care, in relation to the management of patients with long term physical and mental health conditions.<sup>i</sup> These governance structures include incentives to achieve local service reconfiguration of community teams similar to the North American 'medical home' policy (Jackson et al 2012). We argue that these rapidly changing governance systems create uncertainty for interprofessional teams.

Integrating new interprofessional teams to work effectively is a slow process especially if structures do not acknowledge the emotions involved or support staff during periods of uncertainty. The experiences which emerge from the formation of new community based interprofessional teams, sometimes together in new physical locations but often apart, distance managers and front-line staff and reinforce existing divisions between health and social care. (Baxter and Brumfitt 2008; Allan et al. 2005; Hall 2005). We discuss the experiences of clinical staff and their managers in relation to the literature on teamwork, governance and incentives in primary health care. We focus on the emotional reactions to the changes which were expressed by both managers and staff.

## **Background**

Shifting the balance of care from hospital to primary and community settings in the UK has been effected through the introduction of new governance and funding arrangements and, principally, through changes to team structures and professional roles. Governance encompasses the tasks of management (decision-making and control

of organisations) as well as the mechanisms for the relationship between organisations, and the social and political environment in which they operate (Glasby & Peck 2006). Policies for health and social care increasingly emphasise that professionals should work together to promote choice, independence and self care closer to home (Glasby, Martin and Regen 2008; Her Majesty's Government 2007; Glasby & Peck 2006). For social care services, most of which are provided by carers and the private sector, rather than directly by local authorities, there are imperatives to work together at several levels. These include commissioning of services and partnership working (Cameron 2011; Glasby and Dickinson 2008; Glasby and Peck 2006) but such working relies on a collective identity which can often prove elusive (Belanger & Rodriguez, 2008) and may even invoke rivalry and conflict (Brown et al. 2011; Baxter and Brumfitt 2008; Glasby and Peck 2006; Hall 2005).

For partnership to work in the delivery of health and social services, West et al., (2004) assert that interprofessional team effectiveness must be predicated on factors such as organisational commitment, leadership, clarity over objectives, and co-ordination of the different and distinctive professional contributions (Cameron 2011; Poulton and West 1999; West 2004; Mackintosh 1992) More needs to be done to understand these relationships (Cameron 2011; Zwarenstein and Reeves, 2006; West, Brodbeck and Richter 2004) and in particular, how emotions shape interprofessional teams working in primary care (Pescosolido 2002; West and Field, 1995a; 1995b;). Although the effect of strongly negative emotions on staff in the delivery of care within organisations has been recognised for many years (Smith and Cowie 2010; Taylor 2006; Obholzer and Zagier

Roberts 1994; Stokes 1994); particularly in public sector organisations where staff face continuing organisational change (Cardona 1994; Obholzer 1994), this does not seem to be recognised by policy leaders in current service change in health and social care.

Pescosolido (2002) has argued for the emergence of leaders to manage group emotions particularly in times of ambiguity, for example, during the process of strategic change in nursing organisations (Furne , Fink and Ross 2001) and to reconcile the expectations of different groups of staff trying to meet government directives (Smith, et al 2012; Smith and Bryan 2005).

The role of emotions and relationships between people, including the human components of change (Rusaw 2009), within new governance structures is largely invisible in the policy narrative on governance and incentives (Ross et al 2011; Spyridonidis and Calnan 2010). Therefore, for this study, we adopted Davies et al.'s (2005) definition of governance as involving organisations, teams, people and the relationships between them which acknowledges the dynamic nature of change and the roles of people within it and has been used before (Ross et al. 2011). We defined incentives, not just as financial motivators, but as emotional support, leadership, and relationships in teams (Spyriododinidis and Calnan 2010; Rusaw 2009; CSIP 2006; Berwick 2003). While our initial focus was to explore experiences of governance and incentives during organisational change for managers and clinical staff, the focus on emotional responses emerged as a significant theme from the analysis.

## **The Study Design**

This was a three-centre study exploring the professional experience of changing governance and incentive arrangements for the management of patients with long term and complex conditions in health and social care. We used Realistic Evaluation (RE) (Pawson and Tilley 2004; 1997) as a framework for examining the interaction between varied mechanisms at play at an organisational level and to explore causal relationships between system change and key outcomes at professional level. Pawson & Tilley (2004) argue that realistic evaluation is different from other evaluation methodologies as it seeks to understand how a programme works to effect change. This fitted with our desire to understand the human components of system change. The research team was interprofessional and led by an experienced health services researcher. Each site team consisted of a principal investigator and a co-researcher who collected and analysed data in each site.

### *Methods*

The study was approved by the Local Research Ethics Committee in June 2006 and research governance approval was obtained for each site. Data were collected in 2007/8. The sites were local organisations for primary care, Primary Care Trusts (PCTs); two city (A and C) and one semi-urban (B) were selected as representative of PCTs across the UK. In phase 1 Service User Reference Groups (SURG) were held in each site with 32 users with long term physical conditions and non-psychotic mental illnesses to develop vignettes highlighting critical components of care from their perspective. These were used to inform the semi-structured interview schedules for managers (later in Phase 1) and frontline staff (Phase 2).

In total 32 managers and 56 health and social care staff were interviewed, working in newly formed teams delivering front-line care to people with complex physical or mental long-term illness. The teams included social service, district nursing and community mental health teams<sup>1</sup>. Clinical staff working in these teams included: community matrons<sup>ii</sup>, community nurses, occupational therapists, general practitioners, practice nurses, physiotherapists, community psychiatric nurses, social workers and specialist nurses. Participants were selected on the basis of a purposeful sample and snowballing to ensure a diverse group of experienced professionals and support workers and reflect professional groups working in PCTs across the UK. . Interviews lasted between 30 and 70 minutes and recordings were transcribed verbatim and checked by the interviewer.

The interviews elicited views on team performance, incentives and the experience of managing care delivery in the new governance arrangements/partnerships and organisational change.

### *Analysis*

This involved three stages to ensure inter-rater reliability. Firstly, a site specific analysis where each co-researcher developed a list of micro-codes from site data. Secondly, these micro codes were then discussed within the whole research team and amended to accommodate the data emerging across all three sites. A single, integrated coding framework, allowing the linkage of contexts, mechanisms and subsequent outcomes (Pawson and Tilley 1997) ) and containing these micro codes (Atlas codes) was then

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<sup>1</sup> Each team consisted of more than 8-10 staff

developed for use across the sites. Each of the interview transcripts were coded electronically against this coding framework (Byng , Norman and Redfern 2005) through the data handling package Atlas-ti. In the analysis we identified key outcomes such as practitioners' perceptions of their own and patients' wellbeing, and explored these data to look for links between the process of policy implementation (mechanisms) and the context to these key outcomes. In this way we endeavoured to examine processes of change with programme outcomes. We then looked for patterning to develop themes providing provisional explanations through the use of data quotes. Findings from Phase two were presented to each local SURG and feedback was used to add meaning to the interpretation of results. Service user feedback was included in the third stage, a cross case analysis undertaken by two members of the research team not involved in initial data analysis.

Service users, managers and frontline staff views of change (Ross et al. 2009) echoed the government policies of choice, self-help and care closer to home. An example was the concern to reduce hospital admissions and lengths of stay which was regarded positively for a number of reasons, not least of which was that it was what patients or clients themselves preferred. Indeed staff suggested that for people with mental illness hospital admission was a disruptive experience.

I think the outcome really is that most people prefer, if possible, to be treated at home in their own environment with their family [Manager PCT Mental Illness]  
However staff and managers described their struggle to maintain morale in existing teams and the stresses within new teams in the context of new governance and



incentives arrangements. We suggest that the realignment of teams and professional roles can generate resistance and take time to be effective, especially if structures do not acknowledge the painful feelings involved in change and do not support staff during periods of uncertainty. This is firstly because the formation of new interprofessional teams, often designed to reduce admissions and sometimes working together in new physical locations, but often geographically dispersed, involve stressful experiences for managers and frontline staff. And secondly, because new teams appear to have reinforced existing divisions between health and social care (Baxter and Brumfitt 2008; Goddard & Mannion 2006; Allan et al. 2005; Hall 2005). We present data from the managers' and frontline staff's interviews to illustrate these findings.

#### *Managers' Feelings About Change*

Managers stated that it had been difficult to establish coherent teams when different working practices existed across disciplines and sectors, individuals could have different employers with competing priorities and agendas and teams were often physically separate

The XXX structure is a top-down structure; that means that [xx] as director, he is employed jointly by us [County Government] and the PCT, and below him, he has got joint health and social care service managers, and health and social care team managers; half of whom are employed by health and half by us. In other words, its 50:50 funded. ...- so the management is joint but the teams they manage are still functioning separately... [Social/Home Care Services Manager]

Individual managers were often frustrated by not knowing the people in the new organisation.

I worked for two and a half years in the PCT and I could just walk back in their office, I could close their door and walk to the person's desk and talk to them. Now I have got to ask two or three or four people to find out who it is, and when I find them, they won't know what I am talking about... [Social/Home Care Services Manager]

Fear over potential job losses due to restructuring were seen as further destabilising the organisation and colouring individual's reactions to changes in governance.

A lot of people are in doubt about their jobs and my experience has been that there's probably more disruption for us. [Director Community Services & Service Manager Social/Home Care, joint post between health and social/community care]

Managers felt that they were under threat of losing their jobs more than frontline staff.

At individual clinician level, it's unlikely that there'll be changes. What we are dealing with at the moment is the fact that we had five PCTs and five management structures... It only really has an impact on people who are managing teams or had lead roles that don't make sense now we're one organisation. [Human Resources Director]

*Front-Line Professionals' Feelings About Change.*

Frontline staff described the new teams as still being divided physically (thus mirroring the managers' feelings and experiences). These new structural arrangements left them feeling confused rather than fearful (like the managers) of losing their jobs.

The main issue I do have at the moment is that we have a Director that doesn't listen ... he's employed jointly by health and social care, but he's doing what was traditionally two roles and the expectation of the county council is that he's an Area Director like all the others but in reality his job is so much more complex than the others, so he's got to flit between the two and he doesn't have the time really to spend in each area. [Social/Home Care Services Team Manager]

Clinical staff described feeling confused over what was expected of them and not knowing what was being planned for the future.

Nobody tells us about them and the PCT hasn't made it its job to engage with clinicians...[General Practitioner]

The interpretation of policy differs depending on [the] professional background of those in top management. It can be a struggle to work with this. [Social Worker]

There was a sense of an invisible hierarchy sending orders down and creating confusion in the organisation. Clinical staff struggled to make sense of the policy directives and understand what it would mean for them, with some differences noted between health and social care.

[It] was better in when worked in social services...in health, I don't think we had time to look at policies in detail. We might be told 'there is a change to a process

because of a policy but we wouldn't link it...we wouldn't really be made aware of the whole thing. [Specialist Nurse]

Trying to make sense of policy was further exacerbated by the impact of organisational change on structures, which was seen as poorly aligned in terms of providing co-ordinated care for patients.

It's incredibly confusing, it's... We struggle with it, there's not a single member here that doesn't struggle with how the services are set up and how to access them and how Joe Public manages sometimes, the vulnerable Joe Public...[ Social Worker Mental Health]

There were many examples in the data of staff feeling stressed due to increasing workloads, feeling bombarded by initiatives and being near to giving up.

I don't know if it was the end of last year or the beginning of this year, where I felt if I heard one more new initiative, I thought I was just going to give up because I just couldn't cope with any more. [Mental Health Community Nurse]

Another community nurse felt 'rushed'

"I'm always rushed and going onto the next job and may be patients actually...notice...you know, that little special 10/15 minutes that you would sit with them, sort out the problem." [Community Nurse]

A social worker described the changes as having made time for reflection disappear.

Because you need time to think and reflect and make sure that everything is clearly explained. Which does take time and I think that's the problem, you don't have time any more. [Social Worker]

Others described confusion due to rapid changes, half implemented changes and multiple pathways.

I find some of these care packages very fragmented. And it's, to maybe get a social care package it's very difficult for me to initiate that or instigate that. It has to go through a whole referral process which is laborious and tedious and repetitive, so that makes that very difficult. And also accessing even within our own trust the therapy services, to enable people to stay at home. I find the system very confusing and if I find the system confusing, I am sure most other people do as well because I have worked here for a long time.

[Community

Nurse Physical Illness]

This quote is a good example of the professional liking the policy but finding the processes to implement it burdensome. There were other practitioners who reported that they felt experiences for some patients were improved:

we would aim to be spending 45-60 minutes with patients on a visit, unless it's giving medicines or unless they are saying 'I don't want you here for an hour, it's my evening, thanks very much.' I think patients get much more time with us than they would if they were on the ward for instance. [Community Psychiatric Nurse]

...so I mean, certainly the actual factual feedback we have from the patients is that they prefer the service as it now. They much prefer having treatment, being treated in their own homes as opposed to hospital care, so I think it's had a massive impact. [Community Nurse Mental Illness]

### *Incentives and change*

The frontline staff appeared not to recognise positive effects new incentives had on changing their practice. Instead, they referred to intrinsic motivations such as pleasure derived from seeing an improvement in patient outcome or the feeling of having done a good job and extrinsic motivations such as working in a supportive team. The following quote is typical,

My satisfaction comes from when it's done well and when it's done well it's done very well, as I said .....well [GP].

Some of those interviewed mentioned incentives such as training and education. One occupational therapist felt that potential litigation was an incentive, "I don't know that there's any kind of external incentive. I suppose the thought of, um, you know, a misconduct suit or something like that."

Disincentives were also described:

R: And what's dissatisfying for you?

Oh, paper work and I suppose there's also the frustration of when, when you want to help someone and actually there's nothing you can do, that you cannot fix their lives or you cannot fix their health problems [C18 Community Nurse

Physical Care].

For some staff, the increased workload meant that they felt under pressure and wanted to leave.

Well, ultimately, if people get change fatigue and, what concerns me, and I'm seeing this [here] at the moment that people are just, you know, throwing in the towel, had enough. [Senior Community Nurse Physical Care]

#### *Forming new interprofessional teams*

Lack of continuity of care for patients may have contributed further to practitioners' personal frustrations and lack of satisfaction.

However, I do think maybe lots of different people going and doing sort of the same things, you know. I don't know that it's always necessary to have somebody to look at a frame and then somebody else to look at a bed and somebody else to look at a... you know, and I think that can be very confusing.

[Community Nurse Physical Illness]

Efforts were made to address this duplication, for example by co-ordinating visits from different services. Patients and clients themselves developed strategies to negotiate the thicket of disparate and uncoordinated services.

Managers and front-line staff were able to suggest ways in which new teams might be encouraged to form,

If you want people to work together, get them to talk to each other. It's probably saying really things will be better - putting names to faces and all of

that kind of self-system stuff works very well. [Occupational Therapist Physical Care]

Encouraging team working was described in terms of supporting staff to adapt to the changes in the delivery of care. There was evidence that at a team level, mental health team managers were using supervision, which is an established way to acknowledge painful emotions in practice and process defenses (Selby, 1999; Butterworth et al., 2008). Supervision was described as a regular mental health team activity

Then we have, um, an opportunity to meet as a team on a weekly basis to discuss our concerns with individual clients, everybody has individual clinical supervision and there is a group of seniors that meet regularly as well... [Senior Mental Health Nurse]

For managers of teams working with people with physical conditions, references to supervision and support were scarce and focused more on performance (re-skimming):

We're actually going down... re-skimming these individuals and helping them to work through some of the... through supervision, clinical supervision, peer supervision, really sort of sitting down and finding out what is it, what is the cause. [Social Care Services Team Manager]

## **Discussion**

The responses from managers and frontline professionals to new governance arrangements and incentives following the recent restructuring of service delivery in primary care in England suggest that integrating new interprofessional teams to work effectively is a slow process. Staff are uncertain about their new roles and



responsibilities, feel overworked and that their effectiveness has been compromised.

This is congruent with findings by North American (Rusaw 2009) and other UK authors (Peckham & Wallace 2010; Staniland 2009; Glasby & Peck 2006; Goddard & Mannion 2006).

Most professionals in this study broadly agreed with the aims of care closer to home and patient choice, but experienced change as imposed top down with little scope for them to influence it. Some experienced this as personal distress and others as frustration at not being part of a well thought through system. Glasby and Peck (2006) argue that governance can be symbolic, which our data does not support – as the managers appeared equally conflicted. Rather we suggest that this level of symbolic or meaningful leadership had yet to emerge (Spyridonidis & Calnan 2010; Newman 2001). Understanding governance of organisations undergoing change raises major challenges (Dowling, Sheaff and Pickard 2008; Delva, Jamieson and Lemieux 2005). As Ross et al. (2011, 289) argue, governance is not ‘a linear or discrete concept but rather one that displays connections between organisational facets and people relationships that make organisations work’. It is individuals’ perceptions, and how their understandings and perspectives shape their behaviours, which expand our understanding of complex change in large organisations such as the NHS (Spyridonidis & Calnan 2010; Staniland 2009).

This study contributes to the literature on governance by unpacking the intermediate processes between the operationalisation of national governance and incentives policies

aimed at reconfiguring service delivery, and the experiences of individuals at the team level.

Although there were shared feelings of frustration and of not being in control, there were some differences between the experiences described by managers and frontline staff. Not surprisingly, managers tended to focus on the strategic restructuring of services and financial accountability (Smith, et al. 2012; Spyridonidis & Calnan 2010), whereas clinical staff tried their best to meet the expectations of service users by keeping going and getting the job done despite constant change.

Multiple perspectives and lack of a coherent narrative on the restructuring emerged from the manager and clinical staff interviews. These multiple narratives provide further evidence of existing splits between health and social care in the British system (Dowling, Sheaff and Pickard 2008; Baxter and Brumfitt 2008; Goddard & Mannion 2006; Allan et al. 2005; Hall 2005).

For both groups, the findings suggest a misalignment between the policy language and the narrative of change as professionals struggled to make sense of, interpret and apply policy directives in the delivery of care at both management and front-line levels, while demonstrating their commitment to “do a good job”. This illustrates the dangers of oversimplifying definitions of incentives, as in practice they play out in complex ways, influenced by context, professional and personal factors (Peckham and Wallace 2010). Frontline staff experiences of feeling bombarded and overloaded led some to want to give up and leave altogether; however, for others, this was mitigated by the intrinsic incentive to do a good job, in spite of these pressures.

Choices to remain or exit organisations undergoing change have been studied from the perspective of governance in the Canadian health care system (Birch and Petrie 2009). They used Hirschman's 1970 analysis to show how exit, loyalty and voice are strategies to adapt to changes. . Our findings show that some front-line and management staff voiced their views to energise their staff to survive and prosper through, for example, supervision in mental health teams. Showing loyalty, and seeing processes through in the belief that good intentions and ordered processes would deliver positive outcomes was encouraged in some cases, for example the community nurses who identified they had gained more patient contact time. Loyalty and voice are therefore strategies used by NHS staff in these case study sites to adapt to system change. However in the UK context, options around exit may be more constrained given the fewer labour options in the British health care system in 2012 (Sprinks 2012). Exit was a choice referred to by some frontline staff without explanation of future employment options. However imposed exit or redundancy was referred to by managers was not one which has been commented on by Birch & Petrie (2009) or others (Rusbult et al 1988; Hoffman 2006) as it is not generally related to job dissatisfaction.

Our findings contribute to the literature on the role that emotions play in team work (Cameron 2011; Smith, Pearson and Ross 2009). It is note-worthy that a) *both* managers and front-line staff felt themselves to be under pressure although in different ways and b) managers and front-line staff expressed concerns about organisational restructuring. In particular, there was concern about the lack of physical proximity of some new teams, which reduced opportunity for team processes to develop (Delva, Jamieson and

Lemieux 2008). Although some of the literature on teams emphasises the contribution of organisational psychology (West and Field 1995a; 1995b), in general the role of emotions is underplayed, (Franks, Watts and Fabricius 1994).

During the introduction of new community services, staff and managers in new and pre-existing teams had to contend with emotions raised both by taking on new roles in patient care and by forming new partnerships and teams across disciplines, which historically have not worked together (Baxter and Brumfitt 2008; Allan et al. 2005; Hall 2005). However, the emotions expressed in the interviews were not apparently shared between the professional groups, and there seemed little insight into how emotions were being handled by others, although there was evidence of some support for front-line staff within existing teams, if not new teams.

Our findings show that integrating new interprofessional teams is a slow process especially if structures in place do not acknowledge the painful feelings involved in change and do not support staff during uncertainty. Support in the form of supervision appeared to be available for mental health teams, through a reflective, group and/or individual approach but this is a costly in time in a system which is already under pressure. For teams working with people with physical long term conditions, support was described in terms of performance management. Perhaps this is not surprising given Butterworth's et al., review of the clinical supervision literature, which suggests that nurses continue to receive an inadequate amount of supervision (2008). They suggest that as *unfortunately*<sup>2</sup> current research hints at the benefits of supervision on

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<sup>2</sup> Authors' italics

patient outcome, but does not make the link explicitly, this makes clinical supervision less of an organisational priority for physical care teams and it is often not evident within governance structures. Given that clinical matters make up less than 14% of agenda items at NHS Trust Board level (Burdett, 2006), it is not surprising if there is a lack of attention given by some trusts and some managers to supervision and support. The practitioners also emphasise how chaotic and dysfunctional working in the community can feel with discontinuities, half implemented policies and rapidly implemented change. The need for emotional support for practitioners might be lessened if the systems they are working in were better aligned.

Finally, can these findings be useful in other health care contexts? Worldwide, there is an increasing chronic illness burden, a desire to reduce health care costs and an increasing ageing population (Center for Disease Control and Prevention 2009; Shortell et al 2010; Daar et al 2007; Birch & Petrie 2009). Although health care systems in the US, Australia and Canada, for example, are funded differently from the UK, they all face these pressures (American College of Physicians: Health and Public Policy Committee 2008; Birch & Petrie 2009; Peckham & Wallace 2010; Shortell et al 2010; Sweet 2010). Similar attempts have been made to reorganise the health care system in both the US and the UK primary care context, for example to change commissioning patterns and payments and create less fragmented systems which reward the achievement of health outcomes rather than fee for service (Ferlie and Shortell 2001) and to redesign community teams (Jackson et al 2012). Therefore these findings are pertinent for other primary health care systems even if structures differ. While the concepts of governance

are centrally located, the operationalization of them is locally determined which is similar to more devolved systems of healthcare (Ferlie and Shortell 2001). It could also be argued that the UK system is becoming increasingly like the US system as provision becomes more marketised (Davies et al 2005) and integrated community care policies such as the Medical Home are pursued in the US (Jackson et al 2012).

### **Limitations**

The limitations of this study are that the data were collected at one time point (2006-2008) and therefore views expressed could reflect a particular period of turbulence or change within the British National Health Service making its cross sectional nature less valid (Plamping 1998). We addressed this issue as far as possible by focusing the interviews on the current reorganisation. However research shows that the NHS undergoes continual change (Appleby 2012; Smith. Et al. 2012) and that turbulence has if anything increased since 2008 (NHS Staff Survey 2011; Appleby 2012). It is unclear whether staff believe these changes to governance and incentives are qualitatively different from previous changes and of course interviewees did not foresee the current austerity policies of the Coalition government). Our paper adds to the literature on governance by providing a detailed exploration of how professionals experience changes to complex healthcare systems at the relationship and emotional level. We have not contributed to an analysis here of the dynamic of centralisation/decentralisation or that of the market and new performance management. This is published elsewhere (Smith et al 2012).

Lastly the interviews were not complemented by observational or other sources of data. However we believe that rich and deep cross case analysis reassures the reader that these views do not represent just one organisational context but may be transferable to other international contexts.

## **Conclusions**

We suggest the role of emotions and relationships within new governance structures lacks visibility in current narratives on governance and incentives. Policy makers need to take seriously the professional perspective in managing change, within the context of diversity, variously configured teams and individual occupational positioning. In other words, they need to prepare and give voice to service users, carers and professionals when implementing system change.

We agree with Davies (2005) that organisational change encompasses more than formal, legal and reporting structures and that multiple levels of power operate in complex organisational and professional relationships. Organisational change increases pressure and dissatisfaction. Our findings suggest that the conceptual thinking around change locally should take more account of the emotional domain. In particular, implementation of policy change needs not only to be well designed, but to take account of the heterogeneity of professional identities and interests in primary care and the important contribution that support, including clinical supervision, leadership and encouragement can make to professionals' working lives.

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i We do not offer a patient perspective to these organisational changes; this is reported elsewhere (Ross et al., 2009).

ii In England, a community matron is a skilled community nurse who manages patients with complex, long term conditions.